

day, including medication. The average daily cost of partial hospitalization in a community mental health center is only about \$90 per day. When community-based services are provided, inpatient hospitalizations will be less frequent and stays will be shorter. In many cases hospitalizations will be prevented altogether.

This bill will also make case management available for those with severe mental illness or substance abuse disorders. People with severe disorders often need help managing many aspects of their lives. Case management assists people with severe disorders by making referrals to appropriate providers and monitoring the services received to make sure they are coordinated and meeting the beneficiaries' needs. Case managers can also help beneficiaries in areas such as obtaining a job, housing, or legal assistance. When services are coordinated through a case manager, the chances of successful treatment are improved.

For those who cannot be treated while living in their own homes, this bill will make several residential treatment alternatives available. These alternatives include residential detoxification centers, crisis residential programs, therapeutic family or group treatment homes and residential centers for substance abuse. Clinicians will no longer be limited to sending their patients to inpatient hospitals. Treatment can be provided in the specialized setting best suited to addressing the person's specific problem.

Right now in psychiatric hospitals, benefits may be paid for 190 days in a person's lifetime. This limit was originally established primarily in order to contain Federal costs. In fact, CBO estimates that under modern treatment methods only about 1.6 percent of Medicare enrollees hospitalized for mental disorders or substance abuse used more than 190 days of service over a 5-year period.

Under the provisions of this bill, beneficiaries who need inpatient hospitalization can be admitted to the type of hospital that can best provide treatment for his or her needs. Inpatient hospitalization would be covered for up to 60 days per year. The average length of hospital stay for mental illness in 1992 for an adult was 16 days and for an adolescent was 24 days. The 60-day limit, therefore, would adequately cover inpatient hospitalization for the vast majority of Medicare beneficiaries, while still providing some modest cost containment. Restructuring the benefit in this manner will level the playing field for psychiatric and general hospitals.

The bill I am introducing today is an important step toward providing comprehensive coverage for mental health. Leveling the health care coverage playing field to include mental illness and timely treatment in appropriate settings will lessen health care costs in the long run. These provisions will also lessen the social costs of crime, welfare, and lost productivity to society. This bill will assure that the mental health needs of all Americans are no longer ignored. I urge my colleagues to join me in support of this bill.

A summary of the bill follows:

IN GENERAL

The bill revises the current tax code to deter health plans from imposing treatment limitations or financial requirements on coverage of mental illness if similar limitations or requirements are not imposed on coverage of services for other conditions. The bill also revises

the current mental health benefits available under Medicare to deemphasize inpatient hospitalization and to include an array of intensive residential and intensive community-based services.

TITLE I PROVISIONS

The bill prohibits health plans for imposing treatment limitations or financial requirements on coverage of mental illness if similar limitations or requirements are not imposed on coverage of services for other conditions.

The bill amends the Tax Code to impose a tax equal to 25 percent of the health plan's premiums if health plans do not comply. The tax applies only to those plans who are willfully negligent.

TITLE II PROVISIONS

The bill permits benefits to be paid for 60 days per year for inpatient hospital services furnished primarily for the diagnosis or treatment of mental illness or substance abuse. The benefit is the same in both psychiatric and general hospitals.

The following intensive residential services are covered for up to 120 days per year: Residential detoxification centers; crisis residential or mental illness treatment programs; therapeutic family or group treatment home; and residential centers for substance abuse.

Additional days to complete treatment in an intensive residential setting may be used from inpatient hospital days, as long as 15 days are retained for inpatient hospitalization. The cost of providing the additional days of service, however, could not exceed the actuarial value of days of inpatient services.

A facility must be legally authorized under State law to provide intensive residential services or be accredited by an accreditation organization approved by the Secretary in consultation with the State.

A facility must meet other requirements the Secretary may impose to assure quality of services.

Services must be furnished in accordance with standards established by the Secretary for management of the services.

Inpatient hospitalization and intensive residential services would be subject to the same deductibles and copayment as inpatient hospital services for physical disorders.

PART B PROVISIONS

Outpatient psychotherapy for children and the initial 5 outpatient visits for treatment of mental illness or substance abuse of an individual over age 18 have a 20-percent copayment. Subsequent therapy for adults would remain subject to the 50-percent copayment.

The following intensive community-based services are available for 90 days per year with a 20-percent copayment—except as noted below: Partial hospitalization; psychiatric rehabilitation; day treatment for substance abuse; day treatment under age 19; in-home services; case management; and ambulatory detoxification.

Case management would be available with no copayment and for unlimited duration for "an adult with serious mental illness, a child with a serious emotional disturbance, or an adult or child with a serious substance abuse disorder—as determined in accordance with criteria established by the Secretary."

Day treatment for children under age 19 would be available for up to 180 days per year.

Additional days of service to complete treatment can be used from intensive residential

days. The cost of providing the additional days of service, however, could not exceed the actuarial value of days of intensive residential services.

A nonphysician mental health or substance abuse professional is permitted to supervise the individualized plan of treatment to the extent permitted under State law. A physician remains responsible for the establishment and periodic review of the plan of treatment.

Any program furnishing these services—whether facility-based or freestanding—must be legally authorized under State law or accredited by an accreditation organization approved by the Secretary in consultation with the State. They must meet standards established by the Secretary for the management of such services.

ONE-YEAR ANNIVERSARY OF ABDUCTION OF HUMAN RIGHTS ACTIVIST

HON. DAN BURTON

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, September 10, 1996

Mr. BURTON of Indiana, Mr. Speaker, September 6 marks the 1-year anniversary of the Indian Government's abduction of human rights advocate Jaswant Singh Khaira. As I have said in previous statements on the floor about this tragic case, Mr. Khaira was kidnapped after he exposed the widespread use of cremations by Indian authorities in Punjab to dispose of victims of extrajudicial killings.

Recently, India's Central Bureau of Investigation was forced to admit in court that at least 1,000 such cremations had occurred in Punjab. The actual number is certainly many times higher than that. The United States State Department reported that between 1991–93, the Indian Government paid over 41,000 cash bounties to police in Punjab for the killings of Sikhs.

Before Mr. Khaira was abducted, he stated publicly, and with a great deal of courage, that the number of cremations of innocent Sikhs was probably as high as 25,000. He was picked up by authorities a short time after that statement and has not been seen since. That was 1 year ago.

In the video, "Disappearances in Punjab," a policewoman testifies that she saw prisoners in custody whose legs had been broken. These prisoners were reported to have been killed later in staged "encounters."

Mr. Speaker, it is time for the Indian Government to release Jaswant Singh Khaira and own up to the crimes committed in Punjab. With the Indian Government's atrocious human rights record, it is no wonder that there is such a strong movement among the Sikh people for an independent nation of Khalistan.

Mr. Speaker, I hope that the pro-India lobby, and my friends in Congress who have opposed legislation to punish India for its brutal treatment of the Sikhs, the Kashmiris, and other minorities, will pay attention to what is happening over there, and will also call for the immediate release of Mr. Khaira.